CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

CHAPTER IV

COVERED SERVICES AND LIMITATIONS

PROVIDERS OF SERVICE

In the mental health field, physicians, psychiatrists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, clinical nurse specialists-psychiatric, community mental health clinics, and general hospitals (including outpatient departments) may be enrolled as providers billing for psychiatric services. Freestanding psychiatric hospitals including state mental hospitals are enrolled as a special type of facility rendering medical care only for those 65 years and older or those under 21 participating in Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Effective May 15, 1998, Medicaid policy was expanded to include the reimbursement of psychiatric services offered in mental health clinics by employees of the clinic who are licensed clinical social workers, licensed professional counselors, and licensed clinical nurse specialists-psychiatric when billed by the physician-directed clinic. The clinic is required to maintain personnel files that include a copy of credentials for all staff who provide Medicaid-reimbursed services. Mental Health Clinics that have a valid Medicaid provider agreement as of July 5, 2000, which do not currently employ the licensed staff listed above, may continue to receive Medicaid reimbursement for psychiatric services provided by professional social workers and counselors who have a masters' degree in either social work or counseling until July 5, 2002.

The **mental health** clinic must be physician directed; however, the clinic may bill for services provided by individuals, other than an intern or resident, who have completed a graduate degree and are under the direct personal supervision of an individual licensed under state law as directed by the physician directing the clinic. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirement of his or her individual profession.

<u>Direct Supervision</u>

- Both the unlicensed individual and the licensed professional must be employed by the same public clinic.
- The plan of care must be approved and signed by the licensed professional. It must state the need for psychiatric treatment, state the objectives or goals of the psychotherapy which fall within the parameters of Medicaid-covered services and are congruent with the diagnosis and initial evaluation of the client; and include a treatment regimen, projected schedule, and schedule for reevaluation. Documentation in the client’s record should include written records of client contracts, services rendered, the

role of the service to the care plan, and updates of the client's progress. The medical record must contain the notes that are countersigned or signed by the licensed individual to show that he or she personally reviewed the patient's medical history and confirmed the plan of care.

- The licensed supervisor does not have to be present in the room during the session, but must be in the clinic during the session and meet regularly with the professional to discuss the client's plan of care and review the record. The record should indicate that the patient's progress and plan of care are reviewed, at least after every six sessions, by the supervising licensed professional.

Federal law requires that each mental health clinic be physician-directed. The physician does not have to be a psychiatrist. Under this policy, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, and clinical nurse specialists-psychiatric may render reimbursable services without the direct personal supervision of a physician present. In public clinics, these licensed practitioners may supervise the work of unlicensed professional social workers or counselors. However, each mental health clinic must ensure that the federal requirement for the physician direction of the clinic is fully met. Failure to do so could result in the recovery of funds. In addition, DMAS may terminate the Medicaid provider contract when the service provider did not meet his or her requirements.

The State Medicaid Manual § 4320B, published by the Health Care Financing Administration, summarizes the federal requirements for physician direction.

The requirement for physician supervision of all patient care in the mental health clinic is a condition of participation in Medicaid as a mental health clinic. The physician must have a face-to-face visit with the recipient, prescribe the type of care provided, and if services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his or her patient is receiving covered services, the physician must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic must spend as much time in the facility as is necessary to ensure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic, there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement.

The patient care protocols for treatment of Medicaid recipients must reflect the role of the physician. The patient's medical records must document that the physician personally reviewed the patient's medical history, conducted a thorough assessment, confirmed or revised the diagnosis, saw the patient face-to-face, reviewed and signed the plan of care, and is periodically reviewing the need for continued care. The licensed professional must conduct an intake interview with the patient, record the medical history, conduct the intake

assessment, record a diagnosis, and develop the plan of care. If the plan of care is implemented, there must be no more than three sessions or no more than thirty days, which ever is least, before the face-to-face interview with the physician. If the recipient is an existing patient of the physician and the physician has had a face-to-face interview within the past 30 days, the face-to-face meeting may be waived. However, the physician must still review the medical history and intake assessment, confirm the diagnosis, and review and sign the plan of care. The physician must document a review of progress and need for continued care every six months. This requirement must be met for all mental health clinic services billed to Medicaid.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP) who will be responsible for providing and coordinating services necessary to meet all health care needs. MEDALLION promotes the physician/patient relationship, preventive care, and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide a referral for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. Refer to the MEDALLION supplement to this manual for further details on the program.

Psychiatric/psychological services (limited sessions of outpatient treatment) are exempt from the referral requirements of MEDALLION. While reimbursement for these services does not require a referral from the PCP, the PCP must be forwarded a summary of services so the PCP may track and document them to ensure the continuity of care.

MEDALLION II

In areas where the Medallion II program is available, the majority of Medicaid recipients receive primary and acute care through mandatory enrollment in Health Maintenance Organizations (HMOs). There are at least two HMOs per area that have contracts to serve Medicaid recipients. Effective January 1, 1996, the program initially covered Medicaid populations located in Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Poquoson, and Virginia Beach. Effective November 1, 1997, Medallion II expanded to cover populations located in the counties of York, James City, Gloucester, and Isle of Wight and the cities of Williamsburg and Suffolk. Effective April 1, 1999, populations located in the Richmond metropolitan area, Eastern Shore, and Southwest Tidewater regions were covered.

COVERED SERVICES

Psychiatric Services

Psychiatric services are covered by the Virginia Medicaid Program subject to certain

specific exclusions. The requirements for outpatient psychiatric services provided in mental health clinics are:

Recipient Criteria

- Must be Medicaid-eligible (The provider must verify eligibility.);
- Must have a psychiatric diagnosis including current mental status documented in the medical progress notes;
- Must participate and be compliant with treatment (e.g., some individuals with mental retardation [MR] or some babies under the age of two may not have the ability to understand the treatment); and
- Must have documented evidence of a medical evaluation or a plan to obtain a medical evaluation on the presenting problem(s).

Medical Evaluation (conducted by the Primary Care Physician [PCP])

- Rule out any underlying medical condition as causing the symptoms;
- Ensure that any underlying medical conditions are being treated; and
- Perform an annual medical evaluation (Early and Periodic Screening, Diagnosis and Treatment only).

Diagnosis

- Must document the chief complaint related to the diagnosis;
- Must be a psychiatric diagnosis;
- Must be a current (within the past year) diagnosis; and
- Must be related to the criteria for psychiatric services: (A through D must be present.)

  A. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;

  B. Exhibits deficits in peer relations, deficits in dealing with authority, hyperactivity, poor impulse control, or clinical depression, or demonstrates other dysfunctional symptoms having an adverse impact on attention and concentration, the ability to learn, or the ability to participate in employment, educational, or social activities;

  C. Is at risk for developing or requires treatment for maladaptive coping strategies; and

  D. Presents a reduction in individual adaptive and coping mechanism or demonstrates extreme increase in personal distress.

Functional Limitations

- The professional must document how A through D relate/affect the individual's functional limitations (for example, how school performance is affected if the child is hyperactive or has difficulty with attention and concentration); and
- The professional must document symptoms that affect activities of daily living or functioning in the community, school, home, job.

History

- Onset of the diagnosis or functional limitations;
- Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment;

- Reasons that may require consideration (foster care, dysfunctional family);
- History of previous treatment and outcomes;
- Medication history and current medications;
- Medical history (e.g., brain injury)
- Treatment received through other programs or therapies (Department of Rehabilitative Services, Special Education/schools, private providers, licensed professionals, and Community Mental Health Rehabilitative Services)
- Date the individual first received services for this diagnosis.

Plan of Care (elements of the initial plan of care)

- Must be related to the diagnosis;
- Must indicate client-specific goals related to the symptoms and behaviors;
- Must indicate treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation);
- Must indicate estimated length of time that treatment will be needed;
- Must indicate frequency of the treatments/duration of the treatment;
- Must indicate documentation of the family/caregiver participation;
- Must be signed and dated by the qualified professional; and
- Must be reviewed by the professional every 90 days or every sixth session, whichever time frame is shorter, from the date of the professional's signature.

Continuation Plan (elements needed when requesting an extension of services): State whether:

- There has been a relapse;
- There has been a significant change in the environment;
- The individual is at risk for moving to a higher level of care;
- There are any positive or negative changes relative to the symptoms;

In addition:

- Document review of the plan of care by a qualified therapist or personnel prior to the request for extension; and
- Attach the Psychiatric Extension Form, DMAS 412, 6/99 (see "Exhibits" at the end of this chapter for a sample of this form).

Documentation Required (what must be in the medical record)

- History;
- Functional limitations;
- Plan of Care, signed and dated;
- Medical Evaluation (evidence of coordination with the PCP);
- Results of a Diagnostic Evaluation done within the past year;
- Global Assessment Score (GAS);
- Progress notes for each session, which must contain the signatures of the professional and describe: how the activities of the session relate to the client-specific goals, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual], the progress or lack thereof toward the goals, the plan for the next treatment;
- Evidence of Discharge Planning;
- Discharge Summary (including the reason for the discharge and any follow-up needed); and
- Absence of any of the above information may result in a denial or a retraction.
- All services performed by a non-licensed professional must contain the signature of the licensed professional.

TREATMENT LIMITATIONS

Particular Services

Individual medical psychotherapy coverage is limited to once per day. In addition, these services are limited to no more than three sessions in a seven-day period when performed on an outpatient basis. Teaching "grooming" skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered. CPT codes allowing 20–30 minutes are counted as a ½ session, 45–50 minutes as one (1) session, and 75–80 minutes as 1½ sessions.

Pharmacologic management may be included in the individual medical psychotherapy. Separate payment for pharmacologic management will not be made when billed in combination with individual medical psychotherapy or evaluation and management codes.

Group psychotherapy and interactive group psychotherapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy sessions. There is a maximum of 10 individuals per group session.

Psychological and neuropsychological testing is covered when it is related to an apparent or diagnosed psychiatric illness and is a part of the physician's plan for the diagnosis and treatment of a mental illness or disease. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing home, or any placement issue. Medical records must document the medical necessity for these tests. DMAS allows one billing per six-month period, limited to four hours or units. Should the testing exceed the limits of frequency or units, the provider must provide documentation with the bill as to the medical necessity for the testing and a list of the specific tests conducted.

Psychiatric diagnostic interview examination (90801) is all-inclusive and may be billed only once in a 12-month period.

Medical evaluation and management is included in the individual medical psychotherapy codes.

Multiple-family group medical psychotherapy is a non-covered service.

Separate payment will be allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

Non-Covered Psychiatric Services

The following services are non-covered mental health clinic services:

- Broken or missed appointments;
- Remedial education;
- Day care;
- Medical hypnotherapy; environmental intervention; interpretation of examinations, procedures, and data; and the preparation of report;
- Psychological testing done for purposes of educational diagnosis, or school admission or placement;

- Rehabilitative alcoholism and drug abuse therapy;
- Occupational therapy;
- Telephone consultations; and
- Mail order prescriptions.

Psychiatric Limitations

The Virginia *State Plan for Medical Assistance* limits outpatient psychiatric services to an initial 26 sessions in the first year of treatment, with one possible extension of 26 sessions when preauthorized during the first year of treatment. These initial 26 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is the possibility of an additional 26 sessions in subsequent years when preauthorized.

The 26-visit restriction does not apply to the psychiatric diagnostic interview examination. However, only one such procedure per recipient may be billed if medically necessary within a 12-month period.

To check whether authorization is required for additional psychiatric services (the individual has utilized all 26 full initial sessions or all of the sessions subsequently authorized), call the Medicaid HELPLINE at 1-800-552-8627; provide the individual's Medicaid number; and ask for the record of utilization of psychiatric services. The claims history file contains information on paid claims. If a claim has not been paid, the number of available sessions will be overstated. Ask the patient whether he or she has seen anyone else; check the records for any services provided but not paid; and ask the HELPLINE whether any other provider is indicated on the file and the last date of service for which a claim was paid.

Claims for services which exceed the sessions available to the individual without authorization will be denied. DMAS is not responsible for claims denied because the service limit has been reached.

DMAS will also conduct utilization reviews and audits on outpatient psychiatric services to ensure that all program and documentation requirements are being met. If requirements are not met, retraction of payment or the denial of additional services, or both, may occur.

Preauthorization

DMAS utilizes WVMI for preauthorization of all outpatient psychiatric services requiring preauthorization. The provider will have an option of submitting preauthorization requests either telephonically or by fax. In order to approve preauthorization requests, WVMI may request to see any or all of the documentation listed under "Psychiatric Services" in the "Covered Services Section" on pages 3-6 of this chapter.

If more than 26 visits are needed, providers must obtain preauthorization prior to the

completion of the initial 26th visit if within the first year. For any subsequent years, the provider must request preauthorization prior to the provision of any services. When preauthorization is requested, WVMI will inform the provider of the status of the request (approve, deny, pend, reject). If the request is approved, WVMI will indicate the amount of time and number of visits. If treatment is needed beyond this time frame, the provider must request preauthorization prior to the end of the previously approved time period. A request for extension form, DMAS 412, 6/99, must be completed, signed by the physician, and submitted prior to the depletion of the recipient's allocation to avoid a break in coverage. (See "Exhibits" at the end of this chapter for a sample of this form.) In the event that treatment has continued with a lapse in authorizations, authorization may begin on the day it is requested if criteria are met. Any services provided without preauthorization will not be reimbursed.

Retroactive eligibility cases may also be submitted either by telephone or by fax.

It is the responsibility of the provider of psychiatric treatment to ascertain from any recipient being accepted for care whether he or she has received psychiatric treatment reimbursed by DMAS and to what extent his or her allocation may have been used.

Submission of Extension Requests

In order to request preauthorization, the provider must submit the DMAS 412, 6/99, Request for Extension of Psychiatric Services. This form may be submitted via fax to WVMI. Providers may also request preauthorization telephonically by calling WVMI. When calling for preauthorization, the provider must be prepared to provide the same information as is found on the DMAS 412, 6/99. Pend responses and reconsideration requests may also be submitted via fax or telephone. WVMI can be reached at:

WVMI

Phone Numbers: (804) 648-3159
(800) 299-9864
Fax Numbers: (804) 648-6880
(888) 243-2770

WVMI accepts changes for preauthorizations by telephone or fax. To submit changes by fax, send a completed DMAS 412, 6/99, signed and dated by a qualified professional and additional information. (See "Exhibits" at the end of this chapter for a sample of the form.) The additional information must include the tracking number to be changed, the CPT codes affected, the total number of units needed, the dates requested, and an explanation of why the change is needed. A new, updated DMAS 412 6/99 must be submitted if crossing an anniversary date, a change in the type of therapy, or additional sessions are requested. When requesting a change by telephone, the provider must have the same information available to complete the request.

Reconsiderations and Appeals

If services are denied by the WVMI analyst and the psychiatric service provider wants to

request reconsideration of the denial, the provider must follow the reconsideration process described. If a telephone request is denied, the provider may request either telephonic or written reconsideration from the WVMI Preauthorization Supervisor within 30 days of the date of the denial. The WVMI Preauthorization Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. For a written reconsideration request, the provider must submit a letter to the WVMI Preauthorization Supervisor requesting reconsideration within 30 days of the notice of denial, to:

WVMI
Preauthorization Supervisor
Bank of America Center – Suite 402
1111 East Main Street
Richmond, Virginia 23219

If services remain denied following the Supervisor's reconsideration, the provider may file a written request for appeal to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The request must be received in the Appeals Division within 30 days of the date of the WVMI Preauthorization Supervisor's decision letter. **The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS.**

The denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial.

REIMBURSEMENT

Payment for covered services on Medicaid invoices submitted by a mental health clinic is based on the mental health clinic's usual and customary charge to the public within Medicaid limitations.

Client Medical Management Program

As described in Chapters I, III and VI of this manual, the state may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for services to these recipients only:

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient; or
- On written referral from the primary physician. This also applies to covering physicians.

The primary care physician must complete a Practitioner Referral Form (DMAS-70 4/89) when making a referral to another physician or clinic. (See "Exhibits" at the end of the chapter for a sample of the form.) Appropriate billing instructions for these situations are covered in Chapter V of this manual. See "Client Medical Management Program " in "Exhibits" in Chapter I for exceptions to the referral requirement.

Copayment

Copayments are a portion of the allowed Medicaid charges for which a recipient is responsible. Copayments must be paid directly to the provider by the recipient.

The Virginia Medical Assistance Program requires copayment from recipients for each visit to a community mental health clinic. This copayment is $1.00 per visit.

The Virginia Medicaid Program prohibits imposition of copayment requirements for any services rendered to children age 20 and under. Other copayment limitations include:

- No copayment is to be collected for any service which is pregnancy-related.
- There are no copayments for services rendered to individuals who are residents of intermediate care facilities, intermediate care facilities for the mentally retarded, skilled nursing facilities, or tuberculosis or mental hospitals.
- Services to a recipient cannot be denied solely because of his or her inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.
- Copayment does not apply to an emergency or life-threatening condition and will not be deducted from the calculated payment.

Remittance Voucher

The amount of copayment determined by the Medicaid Program will be reflected on the remittance voucher under the columnar heading "Paid by Patient."

EXHIBITS

EXHIBITS TABLE OF CONTENTS

DMAS REQUEST - EXTENSION OF PSYCHIATRIC TREATMENT

Recipient Name: _____ Age: ___ Medicaid ID#: _____
Date of First Service: _____ Diagnosis: _____
Provider Name: _____ Provider #: _____

Specific Symptoms & Behaviors of Present Psychiatric Illness:

Plan of Treatment:

☐ Individual Psychotherapy ___ Sessions per month

☐ Group Therapy ___ Length of Session
___ Sessions per month

☐ Family Therapy ___ Sessions per month
Participants: _____

☐ Chemotherapy (include medication, dose and frequency)

☐ Other: Community resources/agency services that have been/being utilized. _____
_____

Goals of Treatment and Prognosis (Indicate separate goals for each therapy received):

Previous Treatment Received:

Specific Progress Toward Treatment Goals:

Client Specific Reason for Extension:

Signature: _____ Title: _____ Date: _____

For Fax Submissions To WVMI:
Local (804) 648-6880
Toll-Free (888) 243-2770

DMAS 412, 6/99

Instructions for the DMAS 412, 6/99
Request for Extension of Psychiatric Services

The DMAS 412, 6/99 must be fully completed in order for a preauthorization to be conducted.

Recipient Name:	Enter the full name of the recipient receiving services.
Age:	Enter the age of the recipient receiving services.
Medicaid ID #:	Enter the recipient's twelve digit Medicaid ID number.
Date of First Service:	Enter the date that you began treating this recipient.
Diagnosis:	Enter the current diagnosis for which the recipient is receiving services.
Provider Name:	Enter the name of the provider of services.
Provider ID #:	Enter the seven digit Medicaid provider ID number.
Symptoms & Behaviors:	Enter specific symptoms and behaviors resulting in the recipient's need for receiving services.
Plan:	Indicate which services the recipient is receiving and the frequency. Indicate any community resources or other services that the recipient has utilized or is utilizing. Indicate participating members of the family in family therapy.
Dates Requested:	Enter the time frame for which you are requesting preauthorization. Enter month, day and year.
Visits Requested:	Enter the number of visits for which you are requesting preauthorization during the requested time frame.
Goals:	Enter specific goals of treatment. Enter the expectations for the recipient achieving these goals and at what level. Goals should be different for each therapy the recipient receives.
Previous Treatment:	Describe any treatment that has been tried before.
Progress:	Indicate progress the recipient has made towards the goals.
Reason for Extension:	Indicate why the extension of services is needed. Be specific for each recipient.
Signature:	The provider of services must sign the DMAS 412, 6/99, indicate their title and indicate the date of signature (month, day and year).

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (_____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY